COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

June 14, 2005

ADDENDUM No. 1 TO VENDORS:

Reference Request for Proposal:	**RFP 2005-06**
Dated:	**May 25, 2005**
Due:	**June 27, 2005**

Attached is the Department of Medical Assistance Services response to questions/inquiries as submitted by potential offerors before the June 8, 2005 2:00 pm E.S.T. deadline. Anticipated June 13, 2005 DMAS response extended to June 14, 2005. Other event dates and times to RFP schedule remain unchanged.

Note: A signed acknowledgment of this addendum must be received by this office either prior to the due date and hour required or attached to your proposal response. Signature on this addendum does not substitute for your signature on the original proposal document. The original proposal document must be signed.

Sincerely,

Christopher M. Banaszak

Christopher M. Banaszak
Contract Officer

Name of Firm: _____

Signature and Title: _____

Date: _____

Addendum: DMAS Response to Bidders

#	RFP Ref.	Question	DMAS Response
1.	Section 1, Page 8	Under Purpose and Definitions, it states "A disease management program administrator is being sought…Adherence to national evidence-based disease management practice guidelines…" May local and association evidenced based disease management practice guidelines be utilized?	No, only national evidence-based disease management practice guidelines may be used.
2.	Section 1, Page 10	As taking risk affords an evaluation advantage for respondents, please clarify the opt-in versus opt-out approach to enrollment.	The opt-in model means the program is voluntary and Medicaid enrollees must affirmatively choose to enroll in the program. The Disease Management Program Administrator (DMPA) could not count an enrollee as a participant for per member, per month (PMPM) purposes until the enrollee chooses to enroll in the program. The opt-out model means the program is still voluntary for those Medicaid/FAMIS enrollees with the identified disease states. They are automatically enrolled in the program and are considered participants for the PMPM calculation unless the participant chooses to disenroll or is disenrolled from the program.
3.	Section 1, Page 10	1) DMAS indicates that program enrollment will begin with an opt-in model vs. opt-out but will move to an opt-out model once the Centers for Medicare and Medicaid Services (CMS) approval is granted. Can DMAS provide an expected timeframe for this approval? 2) Is DMAS considering waiting until after receiving CMS approval for opt-out enrollment before beginning the program implementation?	1) It is expected the opt-out program will be implemented by December 1, 2005; however, this is dependent upon CMS approval. 2) DMAS will not wait for CMS approval of the opt-out program before beginning program implementation. The disease management program, which is a medical benefit, will run as an opt-in model if the program is implemented

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			before DMAS obtains CMS approval to run an opt-out program.
4.	Section 1, Page 14	For the definition of Quarterly: Normally, reporting this soon after the period gives a false total of services etc., since providers have longer than this to submit encounters/claims. Could this report be do 45 calendar days from the end of the period?	Yes.
5.	Section 2.1 Page 16	What State Plan amendments does DMAS anticipate and will the timing of the amendments affect the award date?	DMAS will make the necessary requests to CMS by August 2005. The timing of the CMS requests will not delay the implementation of the DM program.
6.	Section 3, Page 16	How soon will DMAS know about the request for mandatory status of the pilot? Is it possible the Department will know before the start of the pilot?	Requests to CMS average 90 days for review. DMAS anticipates receiving a response from CMS about the mandatory status by December 2005.
7.	Section 4, Page 18	Vendors are asked to provide a detailed narrative of how they will define and perform each of the required tasks in Section 4 by cross-referencing our proposal response to each RFP requirement. Later, in page 53, we are asked to describe in detail our proposed approach for each of the required tasks listed in Section 3, as well as technical proposal requirements listed in Section 4. Does DMAS expect to cross-reference our response to each task in Section 3? Or should we address these tasks in Section 4, since many of the Section 3 tasks correspond to Section 4 requirements?	Vendors need to define how they will perform the tasks outlined in Section 3 by addressing Section 4 technical requirements. If any tasks outlined in Section 3 are not addressed in Section 4 or the vendor is proposing a new and innovative approach, the vendor is expected to identify how these tasks/approaches will be performed.

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8.	Section 4.1.1, Page 19	Will the potential enrollee/claims data from the Commonwealth have phone numbers to assist with telephonic contacts for enrollment and health status assessments?	Another agency is responsible for entering phone numbers on the file. However, the accuracy of the number cannot be guaranteed. Phone numbers will be provided on enrollee/claims data if a phone number is available and is listed in the enrollee's eligibility file.
9.	Sections 4.1.2 and 4.1.3, Pages 19 and 20	Please note the following requirements that seem to conflict with each other: RFP 4.1.2 asks the contractor to describe how it will ensure continuity of care for participants who are disenrolled on a temporary basis (e.g., not eligible for two months), yet 4.1.3 requires the contractor not provide DM services beyond the month they receive notification from DMAS that the recipient is no longer eligible. Please clarify.	DMAS is not expecting the vendor to provide disease management services during the time the participant is disenrolled from Medicaid. For RFP Section 4.1.2, DMAS is requesting the vendor to clarify how services will continue for an individual who is disenrolled from Medicaid on a temporary basis. DMAS will provide cancel codes to vendors to explain why a participant was disenrolled from Medicaid.
10.	Section 4.1.2, Page 19	Vendor transition plans for enrollees moving into managed care – should we assume that they will be covered by disease management under their managed care organization?	Yes, vendors should assume that program participants will receive disease management services through their new managed care plans. The vendor for this DM program will not continue to provide disease management services to participants after they enter managed care.
11.	Section 4.1.3, Page 20	Is there ever an instance of retro enrollment into Medicaid, as in the case of a recipient whom is eligible for recertification and fails to submit appropriate documents untimely? If so, will the eligibility be retro dated and appear to be unbroken? If so, the DM Contractor will appear to be deficient in its responsibility to provide services to the	The DSM vendor is not responsible for the retro-enrollment period. The eligibility information should be prospective.

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		recipient.	
12.	Section 4.2.3, Page 21	The RFP states "all documents and enrollee materials must be translated and available in Spanish" -- "all documents" is not clear and could be onerous. Could DMAS please clarify its intent with “all documents”?	All documents would mean those documents (brochures, advertisement, materials, etc.) that are prepared for enrollees in this program.
13.	Section 4.3, Pages 22 -24	The following questions were about the Nurse Line: 1) Is the 6% nurse line annualized? 2) Regarding the nurse line assisting participants with referrals. Could DMAS please clarify what you had in mind on this, i.e., referral to the DM program, to physicians, establishing a medical home, etc.? 3) The call reporting requirements presented here suggest that DMAS is envisioning an inbound call center model. Can you please clarify if the department has a specific vision that is preferred around the call center model? 4) Could the two toll-free line requirements be accomplished by using one toll-free line with a menu that breaks out the nurse line functions from the inquiry line functions? 5) Please clarify the specific qualifications required for individuals staffing the toll-free nurse line.	 1) Yes, this is an annualized estimate. 2) Examples of assistance with referrals include referring program participants to their pharmacist for questions about their medications, assisting the participant with requesting a referral for a specialist from the participant’s primary physician, etc. 3) DMAS is asking the vendor to describe how it will handle in bound calls and reporting mechanisms. 4) Yes, one toll-free line could be used for program participants, providers, or interested parties as long as the toll-free line had the ability to triage incoming calls. 5) Section 4.4.2.b.7 (Page 25) of the RFP provides additional detail about specific qualifications required for individuals staffing the toll-free nurse line. Section 4.3 additionally

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			states staff must be…"medical professionals who are fully trained, have the appropriate licensure for their profession, and are knowledgeable about Virginia Medicaid and FAMIS standards and protocols." DMAS specifically used this language to allow the vendor the flexibility to best determine which medical professionals to use to staff the nurse line.
14.	Section 4.8, Page 28	Are contracts with third parties (for satisfaction surveying) necessary to have in place before submittal?	No, however, this function should be included in the implementation plan.
15.	Section 4.14.1, Page 37	RFP 4.14.1 indicates that the first monthly Care Management Report shall cover the month of November 2005. The RFP Schedule of Events (RFP 7.11, page 54-55) indicates the implementation date is December 1, 2005. Please clarify.	The date listed in Section 4.14.1 was incorrect. The first monthly care management report shall cover the month of December 2005.
16.	Section 4.14.4, Page 38	RFP 4.14.4 indicates that nurse line or call center reporting "shall be provided bi-weekly for the first month after program implementation". RFP 4.3.2 (p.24) says this reporting "shall be provided weekly for the first eight weeks after implementation". Please clarify which is correct.	The timeframe for the nurse line in Section 4.14.4 is incorrect. The nurse line reporting shall be provided weekly for the first eight weeks after implementation.
17.	Section 4.14.5, Page 38	Some QM/QI meetings contain "peer review" information and usually is protected by and held in confidence by the Contractor. If the meeting is open for participation by the Department or its designee, is it imperative to include the actual minutes of each meeting?	Yes, it is imperative that actual minutes be taken at each meeting. While the meeting is open for participation by DMAS, a DMAS representative may not attend every meeting and documentation of the meeting's discussion is needed for quality assurance purposes.

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18.	Section 4.14.9, Page 39	Given DMAS is proposing an initial opt-in enrollment model, our experience is that enrollment effectiveness is less predictable than in an opt-out model. If enrollment exceeds the initial DMO projections will DMAS compensate the vendor for the additional participants?	DMAS will compensate the vendor for the number of individuals who are eligible for the program and who choose to participate in the DM program. DMAS will not recalculate the PMPM based on the projection discrepancies.
19.	Section 4.14.12, Page 39	1) Could you please provide a description of the predictive modeling methodology DMAS will use to assess net savings? 2) Also, in the event the DMO will guarantee net savings, does DMAS have anything in mind regarding percent fees as risk or repayment methodologies in case the disease management organization (DMO) misses the net savings guarantee or is this up to the DMO to propose?	1) We are requesting the vendor to provide a description of the predictive modeling methodology the vendor will use to assess net savings. 2) If the vendor is not able to guarantee net savings, the vendor will be responsible for repaying the percentage that was not met back to DMAS up to the cost of the vendor for operating the DM program.
20.	Section 4.15, Page 40	1) Can DMAS provide more specific guidance on what are the expected DMO capabilities regarding monitoring fraud and abuse? 2) Would the state consider it valuable if the DMO could specifically monitor fraud and abuse related to drug utilization? How about monitoring providers not following evidence-based medicine? If so, what does DMAS have in mind regarding follow up with providers not following evidence-based	1) Section 4.15 provides specific information as to what is expected from the vendor in developing its Fraud and Abuse Compliance Plan. The policies and procedures included in the plan must also be in accordance with federal regulations as described in 42 CFR, Parts 455 and 456. 2) This is beyond the scope of the current RFP and will not be the responsibility of the vendor for the DM program.

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		medicine?	
21.	Section 4.16 Page 42	Please clarify Readiness Review date. Stated as October 1, 2005 and October 17, 2005 in 4.16 and as October 17, 2005 under Implementation Plan in 7.1.1.	The Readiness for Implementation date is October 17, 2005.
22.	Sections 4.17, 7.1.1, and 7.11	Please clarify Implementation date(s). Stated that Implementation to begin November 1, 2005 in 4.17, to occur no later than December 31, 2005 under Implementation Schedule in 7.1.1, and to occur December 1, 2005 in 7.11.	The implementation date for the DM program is scheduled to occur by December 1, 2005. Therefore, sections 4.17 and 7.1.1 should state December 1, 2005.
23.	Section 7.5.1.c, Page 49	Does the bidder need to be licensed to conduct business in Virginia as a requirement to bid on this RFP or only after a successful award?	A bidder needs to be licensed to conduct business in Virginia prior to submitting a bid for this RFP.
24.	Section 7.10.4, Pages 53-54	Vendors are required to provide references and resumes for all key staff, which would include the Project Director and Medical Director. Does DMAS want specific staff names for these positions or is it acceptable to list these personnel as to be determined?	We would prefer names, recognizing that after implementation permanent staff will be assigned to the project. The project manager or account manager must be specifically listed.
25.	Section 7.11, Pages 46-47	Can the Critical Elements listed in Section 7.1.1 be incorporated into Chapters 1-6, as enumerated in p. 51-54, or are these to be provided as separate and distinct appendices to the proposal response?	The vendor must ensure the Critical Elements listed in Section 7.1.1 are incorporated into Chapters 1-6. It is not expected that vendors will need to provide this information separate and distinct from the original proposal.
26.	Section 7.11, Page 47	On, DMAS asks us to provide both an implementation plan for an implementation no later than 10/17/05, and an implementation schedule for an implementation no later than 12/31/05. Is it DMAS' intent that we provide	The vendor implementation plan will be required by DMAS by 10/17/05. The 12/31/05 date for program implementation was printed in error. The correct date for program implementation is

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		two distinct scenarios? Or would 10/17/05 mark the beginning of implementation, and 12/31/05 the end?	12/01/05.
27.	Section 10.9 Page 68	Please clarify when performance bonds must be provided to DMAS.	Performance bonds are supposed to be delivered to the DMAS purchasing office no later than 10 days after the vendor receives a notice of award.
28.	Attachment IV, Page 74	Can DMAS clarify if the entire population data set will be provided to the DMO or only data for members identified with the targeted diseases?	The entire population data set of fee-for service eligibles identified for the DM program will be provided to the DMPA upon award of the contract.
28.	General Question	Our pricing models are based to a large extent on the population profile including the prevalence of a particular disease and the distribution of those people in the high, moderate and low severity categories. Given that the state has provided only high level data at this time, will there be an opportunity to adjust pricing based following award based on DMAS' actual claims data and population profile?	No, there will be no opportunity to adjust the PMPM following the contract award.
29.	General Question	Please provide more detail about the pilot program and its current operation.	The program has been operational since June 2004 and will operate until a DSM vendor is operational. We expect the vendor to transfer the pilot recipients into the new program.
30.	General Question	Disease Management is most effective when it is part of a comprehensive unitization management program. The fixed costs of a stand alone program lack the economy of scale present in a comprehensive UM program. The various components of healthcare services have hydraulic effects on each other. An effective program would see	It could be considered as long as the tasks and technical requirements set forth in Sections 3 and 4 the RFP were also met.

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		costs in some areas rise as other areas fall. Calculating savings would also be most efficient and effective as part of a comprehensive UM program. Would the Commonwealth consider a more integrated approach?	
31.	General Question	1) Can a respondent suggest other disease states for DSM in addition to the four-targeted areas? 2) Would the Commonwealth entertain a gain-sharing arrangement on those disease states?	1) No. Only the four disease states will be considered. 2) No, the Commonwealth will not entertain a gain-sharing arrangement on the disease states.
32.	General Question	As costs of medications can significantly impact savings, can the respondent suggest alternates to the PDL preferred drugs?	No. This will not be the role of the DMPA.
33.	General Question	Will the Commonwealth's existing rebate arrangements be considered when assessing program costs?	No.
34.	General Question	Does the Commonwealth have a minimum participant goal for any of the four DSM programs?	No, there is no minimum expected participant goal for the four DM conditions listed in this RFP.
35.	General Question	Should the disease management of children be included in a separate request for proposal?	Bidders can submit a separate proposal that targets children with asthma, but a single proposal can also target children and adults. The Department requests bidders price per member, per month rates separately for children for federal financial reporting purposes.
36.	General Question	If vendors are to include sub-contractors in this proposal, how much information do we need to provide related to these	Vendors must provide the names, functions and experience of the subcontractors.

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		organizations?	
37.	General Question	DMAS has gone down the path of procuring disease management services twice before without contracting. Can DMAS explain why this procurement is more likely to yield a contract?	DMAS fully intends to award a contract based on this RFP.
38.	General Question	Does DMAS have a particular percent net savings expectation?	No, but it is expected the cost of the program's operation will not exceed the cost savings realized through the program. It is the choice of the vendor to propose a percent net savings expectation.
39.	General Question	The phrase "per member per month" occurs throughout the RFP. Enrollment in the program is voluntary at least initially. Does the Department want the proposal bid on a per enrolled recipient per month basis or is it to be priced PMPM of the Medicaid enrollment total? If the former, how does the Commonwealth propose the enrollment be calculated?	The proposed bid must be based on a PMPM of enrolled recipients per month. It is up to the vendor to determine how the enrollment is calculated.
40.	General Question	Disease Management requires a tiered approach based on the stage and severity of the individual members. Calculating cost and savings from the entire enrolled membership could be misleading, as savings for the less severe group will be small and more in the future. Should the vendor propose a tiered payment scheme?	Only one PMPM will be accepted. Vendors need to include risk as a factor when proposing the PMPM rate and in developing the savings methodology.